Continuing Education Module

Postpartum Maternal Health Care in the United States: A Critical Review

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ABSTRACT

Postpartum maternal health care is a neglected aspect of women's health care. This neglect is evident in the limited national health objectives and data related to maternal health. Missed opportunities for enhancing the health care of postpartum women occur in the scope of routine postpartum care. Differing perceptions of maternal needs between nurses and new mothers also contribute to inadequate health care. Therefore, collecting national data on postpartum maternal morbidity, reforming postpartum care policies, providing holistic and flexible maternal health care, encouraging family support and involvement in support groups, and initiating educational programs are recommended. Further research is needed on issues related to postpartum maternal health.

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In 2003, over 4 million live babies were born in the United States, and about 84.1% of the mothers of these babies received prenatal care starting in their first trimester (Hamilton, Martin, & Sutton, 2004). Like prenatal care, the postpartum health care that typically occurs during the 6 weeks after childbirth is considered important to new mothers' health. Unlike the tracking of prenatal visits, however, few national statistics exist on postpartum health-care utilization or postpartum health problems encountered by new mothers (Albers, 2000). Not surprisingly, the extent and content of postpartum health care have been critiqued as too limited to meet the health needs of women (Albers, 2000). Postpartum care also ends as new mothers are still striving to adapt to role changes and a new family environment (Mercer, 1985). As health professionals who practice in a wide range of health-care settings, nurses are in a pivotal position to contribute to health-care policies and practices that may improve care for postpartum women. Therefore, the purpose of this article is to highlight the importance of postpartum maternal health, identify inadequacies in the current practices of postpartum care,

and provide recommendations on policy and practice for a comprehensive approach to care of women after childbirth.

IMPORTANCE OF POSTPARTUM MATERNAL HEALTH

Postpartum Physical Health Status of Mothers

Postpartum maternal morbidities have been reported in studies from several countries. Fatigue or tiredness had a high prevalence rate. At 2 months postpartum, researchers found that the prevalence of fatigue was 55% in Canada (Ansara, Cohen, Gallop, Kung, & Schei, 2005) and 76% in the United States (Declercq, Sakala, Corry, Applebaum, & Risher, 2002). At 1 year postpartum, a study showed the rate of maternal fatigue remained >50% in France and Italy (Saurel-Cubizolles, Romito, Lelong, & Ancel, 2000). Fatigue was found to positively relate to postpartum depressive symptoms and breastfeeding problems (Corwin, Brownstead, Barton, Heckard, & Morin; 2005; Wambach, 1998). However, McQueen and Mander's (2003) critical review reported only a few articles focused on tiredness and fatigue in the postpartum period.

Studies revealed that at 2 months postpartum, many mothers also experienced pain in various parts of their bodies: for example, the perineum (45.9% in Canada; Ansara et al., 2005), cesarean-section incisions (83% in the United States; Declercq et al., 2002), the back (54.5% in Canada; Ansara et al., 2005), or head (23% in Sweden; Schytt, Lindmark, & Waldenström, 2005). The prevalence rate of backaches and headaches remains high over the first postpartum year (Saurel-Cubizolles et al., 2000). Not only is pain a discomfort to mothers, it may impede a mother's timely response to her newborn's cry, thus causing a delay in meeting the child's care needs.

In addition to fatigue, tiredness, and pain, other physical conditions of lower prevalence have a significant impact on mothers' physical and social health. Such conditions include hemorrhoids, constipation, urinary incontinence, disturbed sleep, sleeping disorders, lack of sexual desire, and painful intercourse (Ansara et al., 2005; Declercq et al., 2002; Saurel-Cubizolles et al., 2000; Thompson, Roberts, Currie, & Ellwood, 2002).

Health conditions listed above not only influence mothers' health but also affect children's health. In the United States, the National Maternal and Infant Health Survey in 1988 and its Longitudinal Follow Up in 1991 showed that poor maternal physical health was related to children's reduced general physical health, frequent tantrums, and difficulty in playing with other children, as well as mothers' feeling of difficulties in managing children's behaviors at 3 years of age (Kahn, Zuckerman, Bauchner, Homer, & Wise, 2002). In addition, mothers who perceived their health as poor did not initiate timely vaccination for children (Turner, Boyle, & O'Rourke, 2003), which increased health risks for children. Despite the importance of maternal physical health, many gaps exist in the availability and scope of maternal postpartum health, as described later in this article.

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Postpartum Psychosocial Well-Being and Emotional Health

After childbirth, new mothers undergo the process of attaining their maternal identity that consists of developing an attachment with their baby, having competence in mothering behaviors, and experiencing pleasure when interacting with the baby (Mercer, 1986). The process of becoming a mother is described as a process of appreciation, discovery, learning, and acceptance of the woman's new role, which results in a positive and worthwhile experience (Martell, 2001). However, because of new mothers' lack of baby-care skills, they feel a loss of control in their lives and lack of time and space for themselves. Child-care responsibilities and lack of knowledge and preparation are sources of frustration and fatigue for new mothers (Aston, 2002; McVeigh, 1997; Mercer, 1985).

In addition to adapting to maternal role changes, new mothers may experience a variety of emotional changes. These include transient postpartum blues, depressive symptoms related to situational factors, and postpartum depression, the most well-known and significant postpartum mental disorder (O'Hara, 1995). The prevalence rate of postpartum depression varies across reports. In Yonkers and

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In the Netherlands, a kraamverzorgster *is a versatile, trained woman who provides a family with in-home postpartum care for 1 week to 10 days. Her care includes medical checks, assistance in feeding and bathing the newborn infant, cooking, and general household duties. The mother can relax and recover, secure in the knowledge that her needs, as well as her family's needs, are taken care of.*

colleagues' (2001) study, about 37% (297 out of 802) of new mothers had the potential to be depressed; however, only about 10% of participants in Fowles's (1998) study had the potential for depression. Gaynes and colleagues (2005) concluded in their meta-analysis that point prevalence for major depression was only 1.0% to 5.9% for mothers within 1 year postpartum, while it was 6.5% to 12.9% for both major and minor depressions.

Mothers with postpartum depression experience unbearable loneliness. They feel they are not understood and have a fear of not being able to be themselves again. Uncontrollable anxiety attacks may make them feel as though they are approaching insanity, and they may isolate themselves. They hate themselves and feel insecure, guilty, hopeless, unhappy, helpless, and useless (Beck, 1992; Chan, Levy, & Chung, 2002). They have thoughts of using violence toward themselves or the baby to escape the trap of depression. Sleep during nights becomes impossible because their minds are full of obsessive thoughts about being a bad mother (Beck, 1992; Chan et al., 2002).

Mothers with depressive symptoms possess more negative perceptions of their maternal role performance and of their baby (Fowles, 1998). They also have less verbal interaction and play less frequently with their infants (Righetti-Veltema, Bousquet, & Manzano, 2003). Loh and Vostanis (2004) studied 41 depressed mothers and found that nearly one third of the mothers had pathological anger toward their infants and another one third reported anxiety, obsession with child harm, or lack of emotional response to the child. In turn, infants of mothers with depressive symptoms showed more anxiety, were more fearful of examiners, and exhibited avoidant attachment behaviors. The children were also less happy, less responsive to persons, had lower energy, and had a less secure attachment with their mothers (Righetti-Veltema et al., 2003). The effects of the mothers' depressive symptoms on children's cognitive and emotional development could last even as long as 14 years (Beck, 1998).

POSTPARTUM HEALTH CARE IN COUNTRIES OUTSIDE THE UNITED STATES

Home visits after childbirth by health-care professionals are provided in all northern and western European countries (Kamerman & Kahn, 1993). For example, in the Netherlands, women with normal pregnancies can give birth at home or birth rooms, which are operated by midwives or general practitioners in a hospital. A continuous 1-week home care program covered by insurance for normal birth mothers is provided by *kraamverzorgsters*, who receive a 3-year training program. This postpartum home care includes care for children and mothers and housework services (De Vries, Benoit, van Teijlingen, & Wrede, 2001).

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Despite home visits, mothers can also choose to stay in maternity centers for postpartum care. In Norway, maternity centers established near hospitals are hotel-like environments where new mothers, newborns, and their families can stay together for postpartum care (De Vries et al., 2001). Likewise, in Taiwan, new mothers can choose to stay in private maternity centers where mothers and newborns are taken care of by nurses. A majority of Chinese mothers who choose to stay at home are cared for by their family members for about 1 month to prevent diseases and promote health (Lee, Yip, Leung, & Chung, 2004; Matthey, Panasetis, & Barnett, 2002).

Parental leave is another policy that facilitates maternal and children's health. In Sweden, new parents can take, at most, a 1-year leave at 80% of their salary (De Vries et al., 2001). In Finland, mothers have the chance to take a 1-year maternal leave supported by a state grant (Tarkka, Paunonen, & Laippala, 1999). Whether provided at home or a facility, postpartum care helps new mothers to recover from physical changes of pregnancy and to learn child-care skills.

GAPS IN POSTPARTUM MATERNAL HEALTH CARE IN THE UNITED STATES

National Goals, Surveillance, and Programs

Responding effectively to the health needs of postpartum women requires relevant national health goals, surveillance systems, and programs of care. With regard to U.S. health goals, Healthy People 2010 objectives associated with maternity care focus on pregnancy and its immediate outcomes (U.S. Department of Health and Human Services, 2000a). Although postpartum complications may be considered important, only postpartum depression was mentioned in Healthy People 2010, and its national goal was not established. In contrast, recommendations of the World Health Organization

(WHO) for postpartum care are more complete. The WHO suggested that maternal care be demedicalized, individualized, family-centered, multidisciplinary, holistic, and culturally appropriated. Maternal care was recommended to include medical assessment of postpartum complications, mother-infant attachment, breastfeeding, family visiting during hospitalization, community and partner support, and family planning (Chalmers, Mangiaterra, & Porter, 2001). However, management of postpartum common discomforts, emotional disorders, and difficulties in role attainment were not addressed.

Surveillance of maternal postpartum health status is important to provide a sound foundation for health-care policy. In the United States, the Pregnancy Risk Assessment Monitoring System (PRAMS) designed by the Centers for Disease Control and Prevention (CDC) and state health departments is a system to monitor maternal behaviors and experiences (CDC, 2005). A major limitation of PRAMS is that, currently, not all states participate in the system. Another limitation is that questions about maternal postpartum morbidities, such as depression, and postpartum care utilization are not included in the core PRAMS questionnaire, making inclusion of such questions at the discretion of individual states.

The only other national database on maternal postpartum health is the *Listening to Mothers* survey completed by the Maternity Center Association in 2002 (Declercq et al., 2002). This survey covered postpartum maternal physical and mental well-being, maternal health care, and mothers' competence in their role performance. In the survey, 136 mothers received telephone interviews, while 1,447 mothers completed the survey via the Internet. The data were weighted for educational level, age, ethnicity, geographic region, income, baby's age, and propensity of the on-line survey to reflect the target population. Before weighting, the data showed that most mothers (71%) had some college education or were college graduates, 43% of mothers had an annual household income higher than $50,000, and the majority of mothers (96%) were white. Even though no sampling error was assumed, the survey sample included only women who had a telephone or could access the Internet and who could speak English. Thus, the findings from the *Listening to Mothers* survey are important, but they cannot be generalized to underserved groups, such as non-English-speaking women and those without a home telephone or Internet access. The survey was valuable in its study design and contents; replications of the study can be done with ethnic minority or underserved groups.

The lack of a comprehensive, national reporting system on postpartum maternal health has resulted in inconsistent findings. As noted earlier in relation to postpartum depression, estimates of its prevalence varied widely across studies. Another example of the incomplete and inconsistent health-care findings occurs in the area of postpartum care utilization rates. For example, all mothers in a national, random sample, the *Listening to Mothers* survey (Declercq et al., 2002), reported receiving at least one postpartum, health-care follow-up visit. However, a report from the Office of Public Insurance Counsel and Center for Health Statistics (2004) of the State of Texas showed that 65.2% of women covered by any insurance plan in Texas received their postpartum checkups between 21 and 56 days postpartum in 2003. Another report from the Texas Health Quality Alliance, however, showed that only 25% of a total of 1,401 participants of Medicaid Managed Care members in six counties in Texas had a postpartum follow-up visit (Texas Star Program, 2000). Regrettably, no specific national strategies, plans, or policies are in place to encourage new mothers to obtain postpartum health care.

The Maternal and Child Health (MCH) Block Grant, Title V, of the Social Security Act is the only federal program specifically dedicated to improve health for women and children in the United States. The major funding category in Title V is the MCH Formula Grants provided to states. States coordinate the Title V program with other health programs—such as the Women, Infants, and Children (WIC) Program—to avoid duplication of services and provide effective care for women and children (U.S. Department of Health and Human Services, 2000b). The goals of MCH Formula Grants are to assure accessibility of MCH services, reduce infant mortality and promote child health, provide perinatal care for low-income women, and provide care for children with special needs. The WIC Program provides nutrition education and food coupons for limited juice, milk, cereal, and eggs to low-income, nonbreastfeeding, new

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The entire Listening to Mothers survey can be viewed or downloaded by choosing the "For Health Professionals" link on the Web site for Childbirth Connection, formerly known as the Maternity Center Association (www.childbirthconnection.org).

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mothers. For breastfeeding mothers, limited cheese, beans, canned tuna, and carrots are also provided (U.S. Department of Agriculture, Food & Nutrition Service, 2005). A shortcoming of these programs is their focus primarily on pregnant women and children. Postpartum maternal care is not emphasized.

Missed Opportunities in Postpartum Care and Research

Currently, the major component of the routine 6-week postpartum checkup is limited to vaginal examinations and contraceptive education. In a national survey, about one third of mothers who received a postpartum checkup felt their health concerns were not addressed (Declercq et al., 2002). Common problems that most new mothers encountered over the first 6 months were not identified or addressed in the regular postpartum checkup. Additionally, mothers' lack of knowledge about postpartum health was the main theme that emerged in a qualitative study on the effects of pregnancy and childbirth (Kline, Martin, & Deyo, 1998). Mothers who felt unprepared for the consequences of pregnancy and childbirth were dissatisfied with information received. In another qualitative study, new mothers desired advice about mothering from health-care professionals rather than obtaining information from family or friends (Aston, 2002). Similarly, clinicians felt that postpartum maternal health education about infant care was insufficient (Kline et al., 1998).

Not surprisingly, growing evidence demonstrates that mothers' and nurses' priorities for postpartum care and education may differ. Fichardt, van Wyk, and Weich (1994) identified that new mothers in South Africa were concerned more about needs and problems of self-care than those of infant care. Low self-esteem and dissatisfaction with body image elicited the most responses. Moran, Holt, and Martin (1997) also found that what new mothers most wanted to learn were self-care information about exercise, diet, nutrition, feelings of fatigue, and resuming normal activities, as well as child-care information about illness recognition, the baby's schedule, and calming a crying infant. However, the standard nursing care for postpartum mothers often focuses on mothers' physical changes and care that are medically based. New mothers' needs of emotional care and information about resuming daily life and tending to the infant's daily activities are not adequately provided. An example was found in Ruchala's (2000) study in that nurses' teaching priorities conveyed information about contraception, bladder function, signs of complications, and infant care such as feeding and infant safety. The different perceptions about maternal needs between new mothers and nurses may cause inadequate health care.

Research focused on maternal postpartum health care also is limited. Gaynes and colleagues' (2005) meta-analysis concluded that there is a lack of relevant studies about perinatal depression for national policy guidance, especially related to ethnic differences in the experience of depression. Levitt and colleagues (2004) analyzed 135 postpartum related studies that were either randomized controlled trials or therapeutic or preventive intervention studies conducted in Canada. The authors found that 41 studies were related to breastfeeding, 31 to management of pain, 13 to postpartum support, 11 to depression or anxiety, 10 to medical disorders, and 29 to "other" issues. These findings indicated that psychosocial care of new mothers was not emphasized; rather, breastfeeding and medical care were the primary focus of postpartum care.

RECOMMENDATIONS FOR MATERNAL HEALTH CARE IN THE UNITED STATES

National Goals, Surveillance, and Resources Related to Health of Postpartum Women

National health objectives related to postpartum maternal health need to be expanded to consider maternal morbidities beyond postpartum depression. Such expansion is contingent on expanding national data collection on maternal health status postpartum. Therefore, national survey data on postpartum morbidity should be collected and analyzed to establish an understanding of postpartum maternal health status. Population-based studies in the United States and Australia give guidance for establishing the content of a national database on postpartum maternal morbidities (Declercq et al., 2002; Thompson et al., 2002). These data can provide researchers and health-care professionals with a clear direction for promoting maternal health and preventing morbidity.

National, state, and private agencies (e.g., March of Dimes) that focus on maternal health should use newly emerging data about maternal health needs to stimulate innovation in health-care resources available to women. An example of promoting health care for new mothers that other states can be encouraged to pursue is found in Texas. In 2003, the Texas Legislature passed The Provision

of Information on Postpartum Depression to Pregnant Women Act (House Bill 341; Texas Department of State Health Services, 2003). This law requires health-care providers to offer pregnant women who seek prenatal care a list of professional organizations that provide postpartum counseling and assistance to parents. In addition to this regulation, the contents of services provided, insurance coverage and co-pay by the mothers of the cost, and accessibility of services should also be considered. Moreover, legislators should deliberate how best to coordinate organizations that provide maternal care.

Reconsidering the Scope and Duration of Postpartum Health Care

The content of postpartum care needs to be reconsidered. As discussed above, mothers encounter not only physical discomforts but also psychosocial adaptation problems. Therefore, postpartum health care should include not only physical examinations but also a screening for common health problems, mental disorders, and progress of maternal role adaptation. If needed, referrals to educational programs and mental-health professionals should be provided.

Furthermore, the time limits for providing postpartum care should be reconsidered. Routine postpartum health screening and insurance coverage for these visits should not be limited to 6 weeks; rather, they should be extended to 1 year postpartum (Walker & Wilging, 2000). In addition, the time of postpartum visits should be flexible and based on the needs of the new mothers. In this way, mothers can arrange their time by convenience, and the clinic visits can meet their real needs.

The development of some postpartum problems can be prevented by appropriate care during pregnancy. For example, the occurrence of postpartum depression may be reduced by detecting and treating prenatal depression, which is a predictor of postpartum depression (Beck, 2001); however, prenatal depression is often overlooked because its symptoms are often misdiagnosed as normal emotional fluctuations during pregnancy (Brown & Solchany, 2004). In addition, the incidence of postpartum weight retention, a contributor to obesity in women, can be reduced by closely monitoring weight gain during pregnancy and encouraging breastfeeding and exercise beyond the routine 6-week postpartum visit (Olson, Strawderman, Hinton, & Pearson, 2003).

Home visits by health-care professionals that are provided in European countries can be a model for maternal health care in the United States. Community-based postpartum care programs, which were tested in the United Kingdom, or nurse-managed home visiting programs tested in the United States have resulted in improved mental status, fewer subsequent pregnancies and births, longer intervals between births, and shorter-duration reliance on welfare and food-stamp programs (Escobar et al., 2001; Lieu et al., 2000; MacArthur et al., 2002). Therefore, although the initial cost of home visits is higher than hospital-based care (Escobar et al., 2001), home visits by nurses may be a cost-effective, long-term, postpartum-care model. Enhancing the reimbursement to advanced practice nurses that increase the number of visits covered by insurance may offer a cost-effective means for improving the health of mothers and infants during the first year postpartum.

For more information on the implementation of Texas House Bill 341, log on to www.texaspostpartum.org/HB341.html

The content and delivery of educational programs addressing maternal postpartum care must be strengthened (Aston, 2002; Kline et al., 1998; Moran et al., 1997) and studied for their effectiveness and savings. Informational kits with booklets or media devices such as CD Rom, DVD, or videotape could be provided for new mothers during early postpartum and incorporated into an extended educational program. Additionally, media devices could be shown during waiting times in doctors' offices. The content of the informational kits should be designed around the individual needs of new mothers and contain information about postpartum physical and psychological changes, diet and exercise, the detection of complications and management, strategies to manage common discomforts, infant development, and baby-care skills. A list of counseling hotlines or health-care centers should also be included. Relaxation techniques and time-management skills may also be helpful for new mothers to manage fatigue. Nurses and childbirth educators are in an ideal situation to discuss these informational kits, teach relaxation techniques, and discuss time-management strategies with new mothers. Perinatal education programs that do not already cover the entire pregnancy year can be expanded to address the postpartum period.

Encouragement of Family and Social Support

Encouraging the husband or partner's participation in maternal and child-care needs is recommended.

Gjerdingen, Froberg, and Fontaine (1991) reviewed maternity literature and concluded that emotional and tangible support from the husband was related to the new mother's mental health. Therefore, husbands or partners should be included in any educational program about postpartum changes, maternal care, and child care. Additionally, husbands or partners are encouraged to learn massage techniques to relax the new mother and promote intimate relationships. New mothers are encouraged to discuss time management of house affairs with their husbands or partners. It is important for both mothers and husbands or partners to find a balance among work, child care, house chores, and their relationships.

In addition to husbands or partners, new mothers' social network should also be assessed. For new mothers, support from their family and friends and information from care providers help mothers attain their maternal role (Jackson & Mannix, 2002; Tarkka et al., 1999). In addition, new mothers' mental-health problems were related to low antenatal support and their dissatisfaction with family support (Honey, Morgan, & Bennett, 2003). Therefore, nurses are encouraged to assess the social network of new mothers and to make better use of such intake data when collected by admitting nurses. Social workers who may visit postpartum mothers can also be included to strengthen the social-service aspects of the care plan. People who are important to new mothers and are available to provide support can be invited into the health-care program. Nurses can also be a bridge between new mothers and their supporters. Additionally, mothers are encouraged to discuss mothering skills and share the growth of the baby with family members and friends. With this sharing, potential supporters may be more willing to be involved in child-care needs.

Respite care provided by trained helpers for mothers may be considered a support, especially for mothers of children with special needs. The support should be provided particularly to single mothers because they have higher levels of stress and less social support and are more prone to depression than married mothers (Cairney, Boyle, Offord, & Racine, 2003). This respite care, along with efficient time management, relaxation practices, and massages, may relieve new mothers' fatigue.

Support groups can be a way for mothers to share their experience during the process of becoming a mother. New mothers, especially those who are frustrated with mothering tasks, may not feel alone when they know that other mothers experience similar feelings (Aston, 2002). Child-care skills and management of interpersonal relationships can be discussed in support groups.

Conducting Studies on Maternal Health

Research on postpartum maternal health should give special attention to maternal needs and factors that contribute to postpartum health problems. Cultural differences must be considered in the studies because postpartum health-care concerns may vary among women from diverse cultures. For example, Hung (2005) found that, in addition to maternal role performance, body image, lack of social support, and intimate relations, Chinese new mothers worried about the baby's sex and appearance, the choice of an appropriate name for the baby, and the traditional postpartum care. In addition to the traditional cultural postpartum practices (e.g., staying in bed, no hair washing, or no eating of cold or raw foods), Chinese new mothers may feel distressed and unhappy when they are cared for by, or have conflicts with, their mothers-in-law (Chan et al., 2002; Heh, Coombes, & Bartlett, 2004). Therefore, while conducting studies about Chinese new mothers' health-related issues, the traditional care and the persons providing care should also be considered.

New mothers' health status—which includes physical and mental health status, maternal role adaptation, and quality of life—are other important areas for maternal research. The health of new mothers should be viewed holistically. Assessments used to measure maternal health status by nurses working in advanced practice settings should address complications and discomforts throughout the perinatal period, evaluate mental health status, regard multicultural influences, and be able to quickly be administered.

CONCLUSION

Postpartum maternal health care influences the health of both mothers and their children; however, it is not adequately provided for or emphasized in national policies or national health objectives in the United States. Recommendations to promote maternal health include establishing policies regarding postpartum maternal health, re-evaluating and reforming the program of routine postpartum health care, encouraging family support, offering support groups, designing long-term educational programs,

and conducting research focused on postpartum maternal health.

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